Zoster (shingles)

Date Given	Product*	Physician/Clinic

Other Vaccines

Vaccine	Date Given	Physician/Clinic	Next Due Date

Tuberculosis (TB) Test

Date Given	Physician/Clinic	TST or QFT-G	Results

Influenza (TIV, LAIV)

Date Given	TIV	LAIV	Physician/Clinic	Next Due Date

More information

Washington State Department of Health

- *www.doh.wa.gov/cfh/immunize*

School requirements:

- *www.doh.wa.gov/cfh/Immunize/schools*

Free booklet: *Plain Talk About Childhood Immunization*

- Download – *www.doh.wa.gov/cfh/immunize/forms*
- Order – Family Health Hotline 1-800-322-2588

Childhood immunization and well-child information:

- Child Profile, *www.childprofile.org*

Health connections for your family:

- Family Health Hotline 1-800-322-2588

Tuberculosis Program:

- *www.doh.wa.gov/cfh/TB*

U.S. Centers for Disease Control and Prevention

- *www.cdc.gov/vaccines*
- 1-800-CDC-INFO (1-800-232-4636)
- TTY: 1-888-232-6348

Ask your doctor or clinic to be sure the immunizations on this recore are entered into the Washington State Immunization Registry. Your Lifetime Immunization Record may be needed for child care, school, camp, college, the military, travel, employment, or long-term facilities. Talk to your doctor or clinic about your immunization questions, or visit the Washington State Department of Health: *www.doh.wa.gov/cfh/immunize*

Partially funded by the federal Vaccines for Children program.
If you have a disability and need this document in another format, please call 1-800-322-2588 (711–TTY relay).

325-0073B DOH 348-001 January 2012

Lifetime Immunization Record

Name: _____

Birth Date: _____

Allergies/Vaccine Reactions: _____

_____

_____

CHILD PROFILE

Washington State Department of Health

Bring this record to every visit with your doctor or nurse.

Hepatitis B Immune Globulin (HBIG)

Date Given	Hospital/Physician/Clinic

Hepatitis B (HepB) Use lines on back under Other Vaccines if needed.

Dose #	Date Given	Product*	Physician/Clinic	Next Due Date
1				
2				
3				

Rotavirus (RV)

Dose #	Date Given	Product*	Physician/Clinic	Next Due Date
1				
2				
3				

Diphtheria, Tetanus, Pertussis (DTaP, DT)

Dose #	Date Given	Product*	Physician/Clinic	Next Due Date
1				
2				
3				
4				
5				

Haemophilus influenzae type b (Hib)

Dose #	Date Given	Product*	Physician/Clinic	Next Due Date
1				
2				
3				
4				

Polio (IPV, OPV)

Dose #	Date Given	IPV	OPV	Physician/Clinic	Next Due Date
1					
2					
3					
4					

Pneumococcal (PCV, PPSV)

Dose #	Date Given	PCV	PPSV	Physician/Clinic	Next Due Date
1					
2					
3					
4					

Measles, Mumps, Rubella (MMR)

Dose #	Date Given	Product*	Physician/Clinic	Next Due Date
1				
2				

History of: ❑ Measles, date_____
❑ Mumps, date_____ ❑ Rubella, date_____

Varicella (chickenpox)

Dose #	Date Given	Product*	Physician/Clinic	Next Due Date
1				
2				

❑ History of chickenpox, date_____

Hepatitis A (HepA)

Dose #	Date Given	Product*	Physician/Clinic	Next Due Date
1				
2				

*Use the Product column to write the name of the vaccine. Record combination vaccines in the section for each individual component. For example, record each component of the Pediarix vaccine: HepB, DTaP, and IPV. **If you need more room to record vaccine doses, use the lines on the back under the Other Vaccines section.**

Meningococcal (MCV4, MPSV4)

Date Given	Product*	Physician/Clinic	Next Due Date

Human Papillomavirus (HPV)

Dose #	Date Given	HPV2	HPV4	Physician/Clinic	Next Due Date
1					
2					
3					

Tetanus, Diphtheria, Pertussis Booster (Tdap,Td)

Date Given	Tdap	Td	Physician/Clinic	Next Due Date